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ABSTRACT

In early 1972, a survey was taken of the continuing education attitudes, practices, and related needs of Kentucky physicians. A representative sample of 305 Kentucky Medical Association (KMA) members was interviewed by telephone, with 86 percent giving complete responses. A profile of KMA physicians was developed. It was ascertained that there is much involvement in continuing education, although 78 percent of the respondents found themselves unable to participate in formal continuing education as much as desired. There is a strong preference for medical-center-based programs (for clinical programs as opposed to medical care delivery programs) and for self-assessment endeavors. A suprisingly high percentage favor continuing education as a prerequisite to continued membership on hospital staff or in KMA, to specialty recertification, or even to relicensure. A great majority believe that physicians should bear the costs of their continuing education. (Author/MSE)

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CONTINUING EDUCATION PRACTICES AND INTERESTS OF KMA PHYSICIANS

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SUMMARY

In early 1972 a survey of the continuing education (C.E.) attitudes and practices, and the needs of Kentucky physicians was conducted by the Ohio Valley Regional Medical Program Office. The survey of a representative sample of 305 KMA members was conducted by telephone interview with 262 (86%) complete responses. A profile of KMA physicians was developed and it was ascertained that there was much involvement in C.E., despite which 78% found themselves unable to participate in formal C.E. activities as much as "desired". There is a strong preference for medical center based programs; clinical programs versus medical care delivery programs and for self assessment endeavors. A surprisingly high percentage favor continuing education as a prerequisite to continued hospital staff or KMA membership, specialty recertification, or even relicensure (32% in favor). A great majority believe physicians should be principally responsible for the costs of their continuing education.

Continuing Education Practices and Interests of KMA Physicians

During January to February, 1972, a survey of the continuing education (C.E.) activities of Kentucky physicians was conducted by the Ohio Valley Regional Medical Program (OVRMP) staff. The Kentucky Medical Association (KMA) and the offices of continuing education at the Universities of Kentucky and Louisville co-sponsored the survey and helped to design the questionnaire.

The questionnaire copy was mailed to 2800 KMA doctors involved in actual patient care, 305 of whom were selected as a carefully designed representative sample of the total membership in terms of practice locations and speciality, age, sex distribution and number of years in practice. The responses of these two basic groups are noted below:

Study Groups

	Mail		Sample	
Net Number	2495	(100%)	305	(100%)
Responded	1031	(42%)	262	(86%)
Incomplete or No response	1164	(58%)	33	(14%)

Response is obviously much more complete from the sample group. Neither the non-respondents in the sample or mail group, nor the respondents in the mail group, differed significantly as a group in basic characteristics (e.g. age, sex, location, specialty, etc.)

from the respondent (262) sample group. Therefore the sample respondents have provided information believed to be generally applicable to KMA physicians as a whole. The 262 physicians in the sample are the subject of this report. Detail analysis of the total group who responded by mail will be the subject of a later report.

Questionnaires were mailed to the 305 physicians in the sample with a request that they study the questionnaire but hold it and await a telephone call from an OVRMP interviewer. On this basis, the physician was prepared for the interview by having considered the appropriate answers to the questions. Where uncertainty existed, the questions could be further clarified by the interviewer and solicited or unsolicited general comments recorded. At the completion of the interview the physician was asked to also return his completed questionnaire by mail as a cross-check of written answers against interview responses. Physicians were generally cooperative. The vast majority were readily contacted by telephone at pre-arranged times. A few could not be located during the two month survey period. Some would give only incomplete or partial answers and a very few refused to participate. We were thus able to obtain 262 (86%) usable questionnaires from the sample.

The survey is concerned with several aspects of the practices, desires, needs and attitudes toward C.E.; its financing, and its essentiality to continuing full qualification as a physician were also considered. The relative data are the subject of the item by item results which are presented in the following pages.

1. A partial profile of KMA physicians by several parameters is indicated in tables on the facing page (1, 2, 3, 4). The median, and largest age group (38%), are those age 40-49, with 90% being between the ages of 30-59. Similarly, the median number of years in practice was somewhere between 15 to 19 and 54% of physicians had been in practice from 5 to 20 years -- 2/3 up to 25 years. Corresponding with the general and physician population, almost 50% of doctors in the sample were located in areas of 50,000 or more population; but, reflecting the rural nature of Kentucky, 33% were in towns or centers of less than 10,000 population. The distribution of specialty practice among KMA physicians is represented in Table 4. Forty percent (40%) identified themselves specifically with general or family practice. It should be recognized that other physicians in general internal medicine, pediatrics, and perhaps surgery, also function part of the time as primary care physicians

TABLE 1

Distribution of Physicians by Age

Age	Physician No.	Physician %
1. Under 30	2	.8
2. 30 - 39	69	26.3
3. 40 - 49	100	38.2
4. 50 - 59	66	25.2
5. 60 - 65	25	9.5
TOTAL	262	100

TABLE 2

Distribution of Physicians by Geographic Location

Geographic Location	Physician No.	Physician %
1. Towns under 5,000	59	22.5
2. 5,000 - 9,999	27	10.3
3. 10,000 - 49,999	46	17.6
4. SMSA, 50,000 +	130	49.6
TOTAL	262	100

TABLE 3

Distribution of Physicians by Years in Practice

Years	Physician	
	No.	%
1. Under 5	20	7.6
2. 5 - 9	50	19.1
3. 10 - 14	44	16.8
4. 15 - 19	47	17.9
5. 20 - 24	33	12.6
6. 25 - 30	26	9.9
7. 30 - 34	25	9.5
8. 35 +	8	3.1
9. No answer	9	3.4
TOTAL	262	100

Source: American Medical Association

TABLE 4

Distribution of Sample Physicians by Specialty

Specialty		Physician No.	Physician %
1.	Internal Medicine	19	7.3
2.	Subspecialty (IM)	24	9.2
3.	General Surgery	22	8.4
4.	Subspecialty (Surgery)	29	11.1
5.	Psychiatry	7	2.7
6.	Obstetrics and Gynecology	14	5.3
7.	General Practice	95	39.3
7a.	Family Practice	8	
8.	Pediatrics	22	8.4
9.	Other	22	8.4
TOTAL		262	100

Source: American Medical Association

2. We began by wanting to learn some basic information regarding the current activity of physicians in C.E. A recent report (1) reveals that the number of registrations by physicians in the C.E. courses of American medical schools has increased 15 times during the past 16 years from approximately 19,000 to 276,000 annually. In the academic year just prior to the survey, 48% of Kentucky's physicians had attended no formal C.E. programs, 12% attended three or more and 36% at least one or two. (Chart #1) As one measure of self-stimulation in C.E. almost 36% (Chart #2) had at some recent date taken a self-assessment examination. The kind of physician more likely to take such tests is indicated in some detail on page 9.

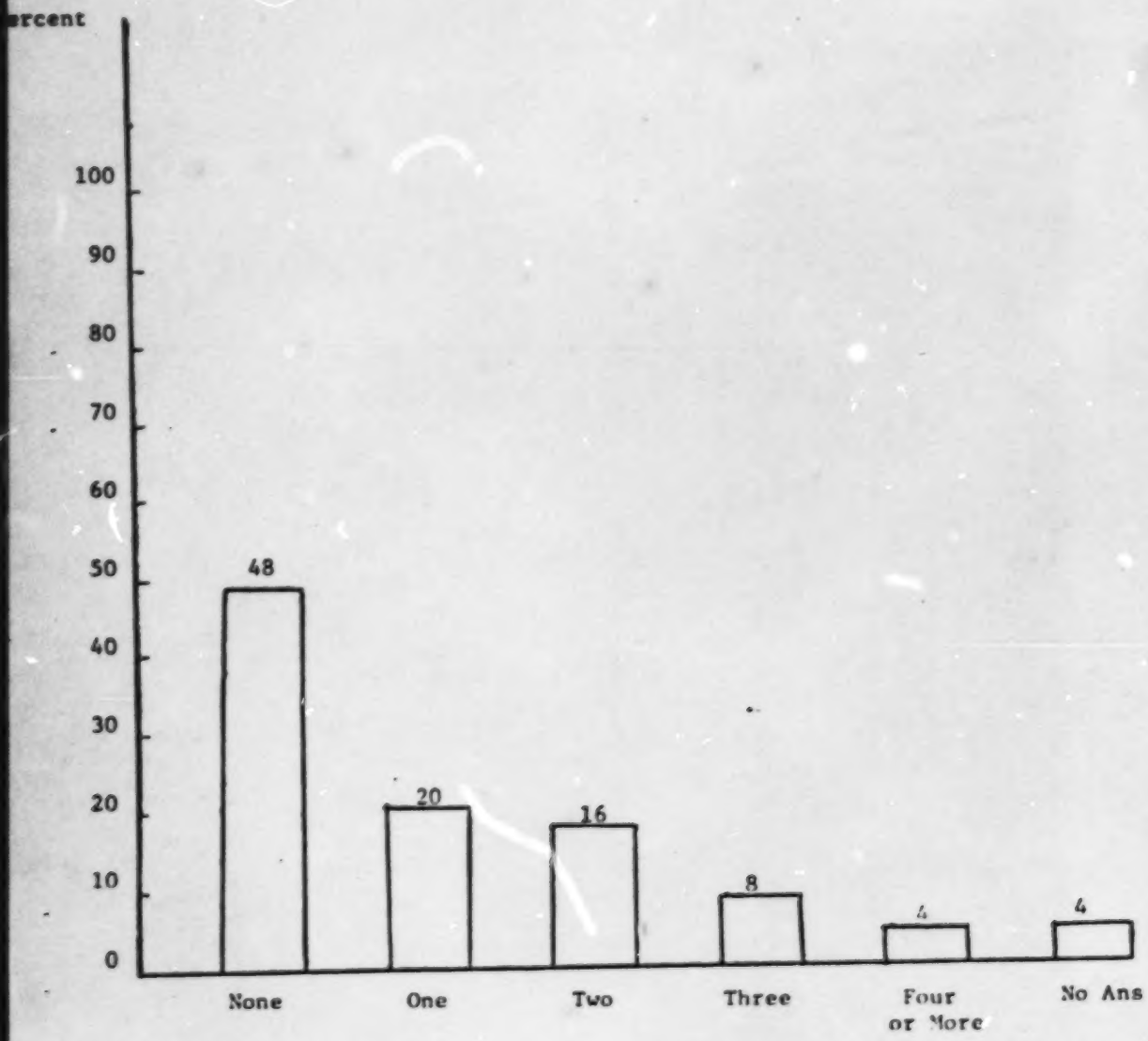
Similar to the findings in a number of other U.S. studies; (2 & 3) medical reading; the scientific portions of state and national medical society meetings; and formal C.E. courses all rank high with Kentucky physicians as methods of ongoing education. (Table 5) The repeated endorsement of medical reading is noteworthy in this day of many forms of more rapid communication. It is important to realize that reading along with the use of audio-tape records, consultations, correspondence courses, television, and self-assessment exams are methods of gaining knowledge which it is impossible to document except indirectly by the scrutiny of challenge examinations. A great deal of C.E. at the individual level has a top priority with many physicians. Close behind come votes for the formalized and traditional sessions between "teacher" and "student" in various professional meetings and "courses".

The number of C.E. courses in which physicians participate did not seem to be affected by distance from a medical center, nor by town of residence, except for towns of 5-10,000 population where an increased proportion of physicians attended at least one or more C.E. courses during the year. As expected there is a general decline in formal course attendance with advancing age.

Seventy-eight percent (78%) of Kentucky physicians indicated they were not able to "participate in as many continuing education activities as (they desired)". This response suggests that despite the considerable efforts of both educators and physicians, expectations and needs have not been fulfilled.

Chart 1

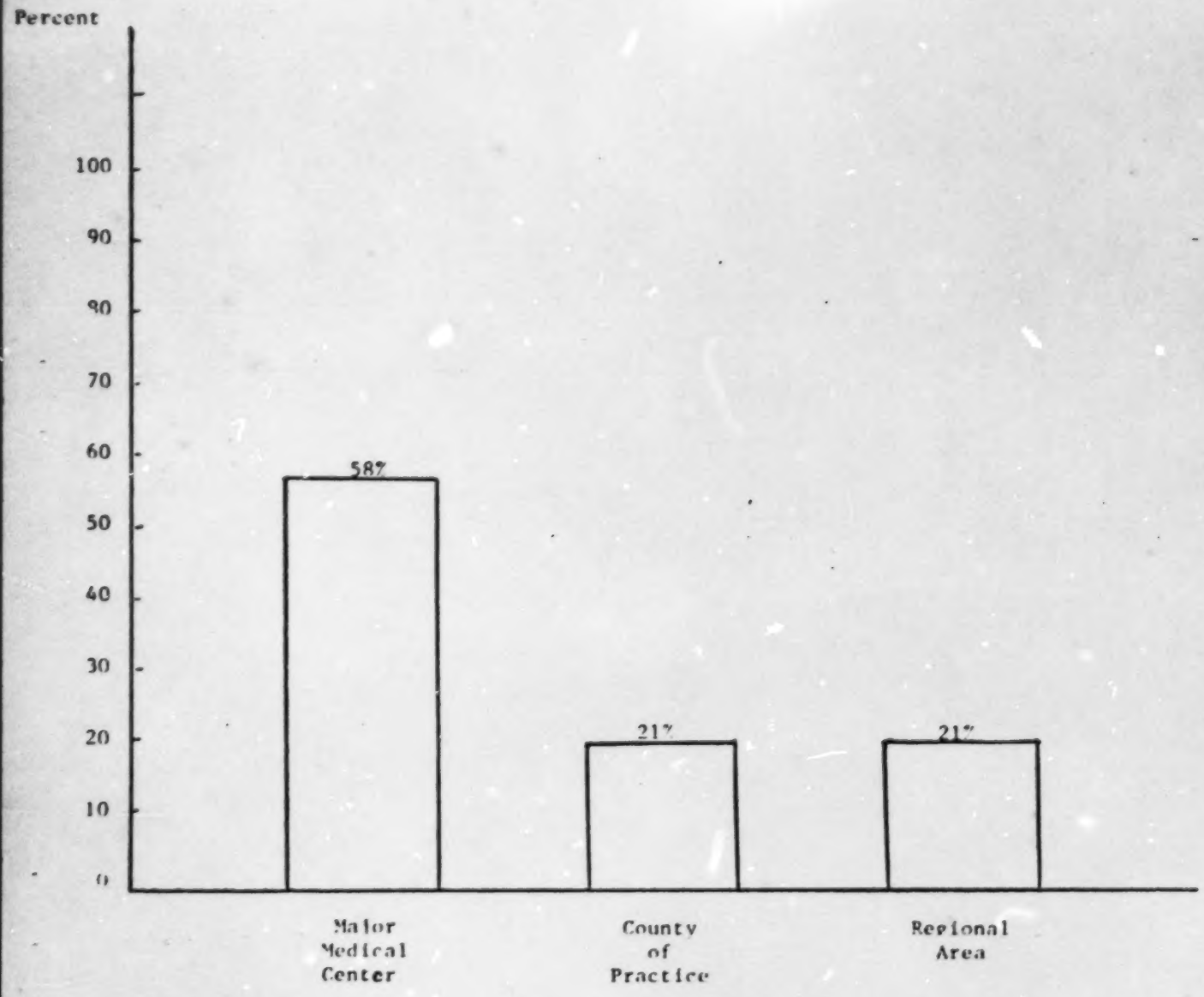
Distribution of Physi ians by Number of Continuing Education Courses Taken



Question 3

CHART 2

Distribution of Physicians by Location Preferred for Continuing Education Activities



Question 6a

TABLE 5

DISTRIBUTION OF PHYSICIANS BY THEIR RANKING OF MOST USED METHOD OF OBTAINING CONTINUING EDUCATION

	FIRST	SECOND	THIRD	TOTAL	WEIGHTED TOTAL
1. Medical Reading	154	43	20	217	568
2. State & National Med. Soc. Mtgs.	21	45	42	108	195
3. Formal CE Courses	21	28	32	81	151
4. Audio Tape Records	27	20	25	72	146
5. Informal Conversations with Peers	6	30	39	75	117
6. Consultations	5	28	34	67	105
7. Hospital Staff Meetings	4	23	22	49	80
8. Local Medical Society Meetings	4	19	7	30	57
9. Med. Sch. Faculty in Community	1	6	9	16	24
10. Correspondence Course	4	2	3	9	19
11. Medical TV Programs	0	1	5	6	7

Question 2

3. How do physicians like to learn? What teaching learning methods do they prefer? The techniques which rank among the first three preferences (Table 6) are those which show the physician how something works or how to do something, or places him in a participant situation in the discussion and debate of data and information. There is a substantial gap between the weighted preference for these approaches and the standard lecture, backbone of most regular C.E. courses. The lecture, in turn, stands at a midway point of acceptability between these informal methods of teaching and the less common tutorial or self-instructional forms with which many physicians have had very little experience. After three years of effort in Kentucky open broadcast medical television rates poorly with physicians.

Other variations: Demonstrations are appreciated more by those age 50-59; supervised clinical practice more by those under age 39; informal group discussion by those over 60. The lecture is slightly more favored by younger physicians and slightly less by older. Demonstrations are preferred somewhat more by internists and least by sub-specialists. Supervised clinical or tutorial experiences find the most favor among general and family physicians; least among sub-specialists. The lecture rates poorly with internists.

Of the small number who had an opinion on the use of audio-tapes they were of greater interest to sub-specialists and of least interest to internists. The farther physicians were located from a medical center (more than 50 miles), or in smaller towns, the more interested they are in demonstration or tutorial forms of learning and the less interested in gadget approaches such a audio-tapes, T.V., films, etc. There is no significant difference in the learning technique preference of physicians who did or did not engage in C.E. activities during the previous year.

TABLE 6

Distribution of Physicians by their Ranking of Techniques of Presentation

Techniques	Rank				Weighted Total
	First	Second	Third	Total	No.
1. Group Discussion	58	56	35	149	321
2. Panels and Symposia	40	52	42	134	266
3. Demonstration	60	32	15	107	259
4. Lecture	29	34	42	105	197
5. Supervised Clinical Practice	19	16	27	62	116
6. Film	11	27	21	59	108
7. Audio Tape	16	13	25	54	99
8. Medical TV Program	4	6	18	28	42
9. Laboratory Experience	4	4	5	13	25

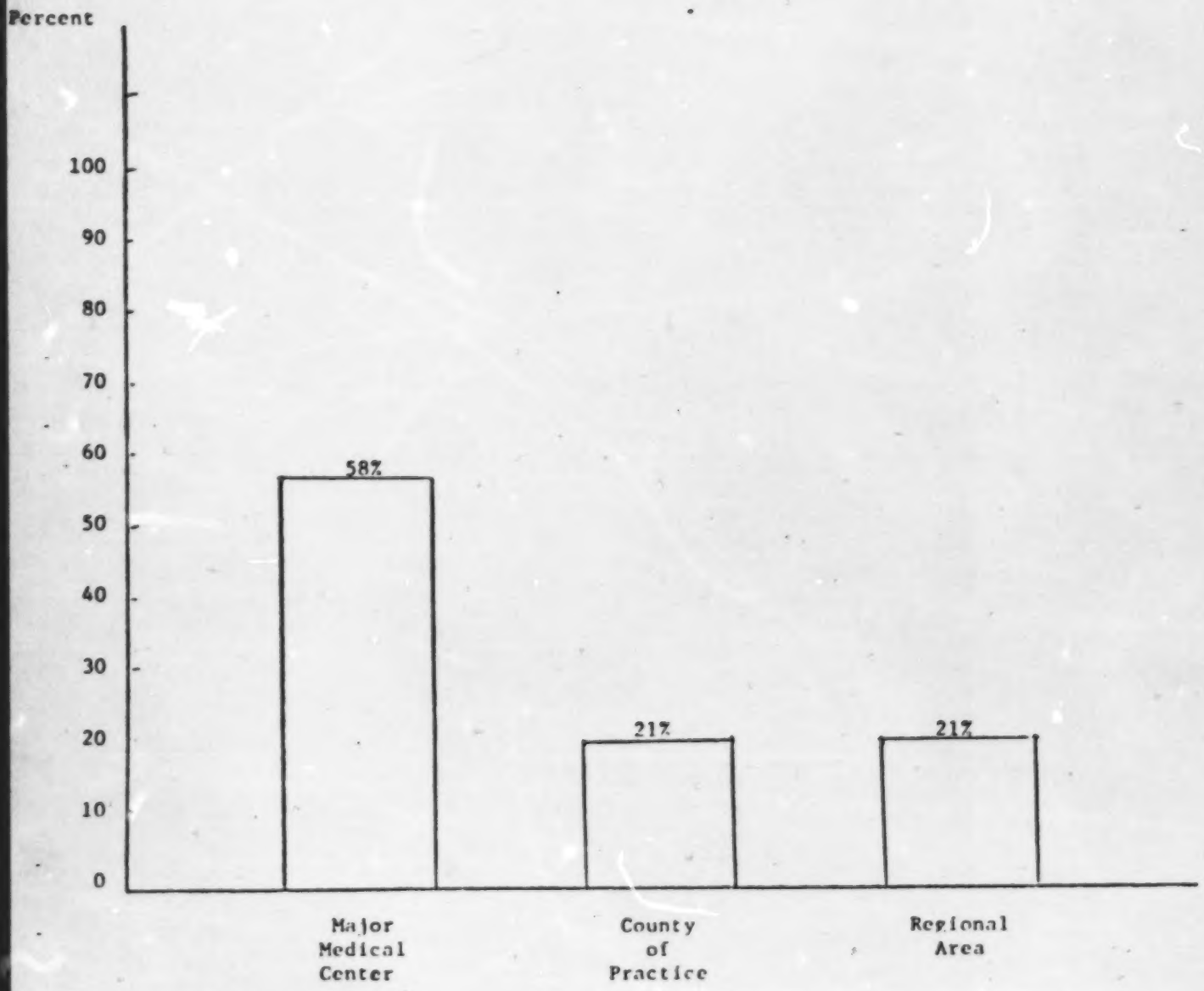
Question 5

4. Pedagogical theory insists that adult learning is most effective when carried on in the work environment in context with usual work problems. The theory seems applicable to physicians and other health professionals. The 1970-71 AMA report on medical education[1] revealed that during the period from 1961 - 1971 formal courses in continuing medical education (as a proportion of all such courses) had declined in medical schools from 55% to 38%. During this same period of time, they increased in community hospital centers from 9% to 26% of all such offerings. The current interest in peer review and medical audit for <u>strictly educational purposes</u> (vs. administrative or fiscal purposes) rests upon both theory and evidence that physicians, like others learn best how to improve the quality of their product by examining that product over a period of time. An analogous question: How would the makers of Chevrolet automobiles know how to make a better Chevrolet unless they examined the successes and failures of previous models?

In the light of that theorization, and the current trend for medical education in the community hospital setting, it is somewhat unsettling to note in Chart 2 the preference of Kentucky physicians for their continuing education activities -- 58% at major medical centers, and only 21% in their own practice area.

CHART 2

Distribution of Physicians by Location Preferred for Continuing Education Activities



Question 6a

5. Certain reasons have long been given (and accepted as genuine) why physicians cannot participate in C.E. as much as they would like. What are the principal obstacles to such participation? Almost 100% of the answers fall within six categories summarized in Table 7; 84% in the first three categories.

Subgroup analyses indicated, as one would expect, that the proportion of physicians who have "no one to care for their practice" during an absence are most numerous in small towns, at distances more than 50 miles from our three regional medical centers, or among those in general or family medicine. The latter group comprises, no doubt, the largest body of solo, or very small group practitioners. Yet, this is the same group of physicians which displays a strong preference (page 6) for C.E. at the medical center to which they cannot come readily because "there is no one to care for their practice"! A similar paradox is found with the obstacle: a "lack of opportunity in the area" of the physician's practice for C.E.

While this paradox is being pondered, it is important to notice also that in no case by either location of practice or type of practice were there <u>less than 1/3</u> who attributed an inability to "sign out" their patients to someone else as a primary obstacle to their obtaining adequate continuing education. Surely, in towns of more than 50,000 population, and in our two major population centers, there must be some solution to this most frequently cited obstacle to C.E.

TABLE 7

Distribution of Physicians by Principal Obstacles
to Obtaining Continuing Education

Obstacles	Physician No.	Physician %
1. No one to care for practice	109	31.7
2. Scheduled at inconvenient time	104	30.2
3. Lack of opportunity in area	75	21.8
4. Subject matter does not fit needs	16	4.6
5. Excessive cost	22	6.4
6. Previous unsatisfactory experience	18	5.2
TOTAL	344*	99.9

Question 8

*Some physicians chose more than one category.

6. We were keen to learn the general types of information in which physicians were most interested. Concern with clinical concepts, particularly the steady and insistent barrage of new methods, approaches and ideas, is reflected in the responses regarding a priority for "new" ideas, better knowledge of a restricted field or making sure that the "old" is indeed still in vogue and still clearly understood. In contra-distinction, despite the considerable discussion, agitation and potential personal threat or benefit to physicians and their patients alike, there was a very modest concern with learning about new medical care delivery concepts. That general trend carried through all analyses of the data regardless of age, specialty or the length of time in practice, or the practice location. (Table 8)

7. A recent development in helping the physician to determine his own strengths and weaknesses is the self-assessment examination as seen in examinations ("core content") sponsored by the Academy of Family Physicians and the American Colleges of Physicians and of Surgeons, among others. This study revealed a previously unperceived and considerable Kentucky physician interest in this approach. Seventy percent (70%) of the sample believed that the KMA should take some sort of lead in developing self-assessment examinations and more than 1/3 (36%) had themselves taken such an examination. (Chart 3)

Of those who had taken self-assessment examinations, what groups of physicians did so in a proportion exceeding 36%, suggesting that this approach might have more than usual value to them. Included in this group were physicians who:

1. more frequently used self-instructional approaches (eg. audio-tapes) as preferred means of C.E. except paradoxically, those who relied largely on medical reading.
2. found as principle obstacles to adequate C.E., a "lack of opportunity" in their area or an inability to leave their patients and their practices.

The study indirectly associates the latter two categories (#2 above) by indirect analysis as primarily those physicians located in smaller towns and at more distant points from the medical centers. Paradoxically a less than expected proportion of those who have found their C.E. exposures to be inadequate had taken advantage of the self-assessment examination route. It is, of course, unknown whether they were acquainted or unacquainted with the self-assessment examination other than as posed in a question on this survey.

TABLE 8

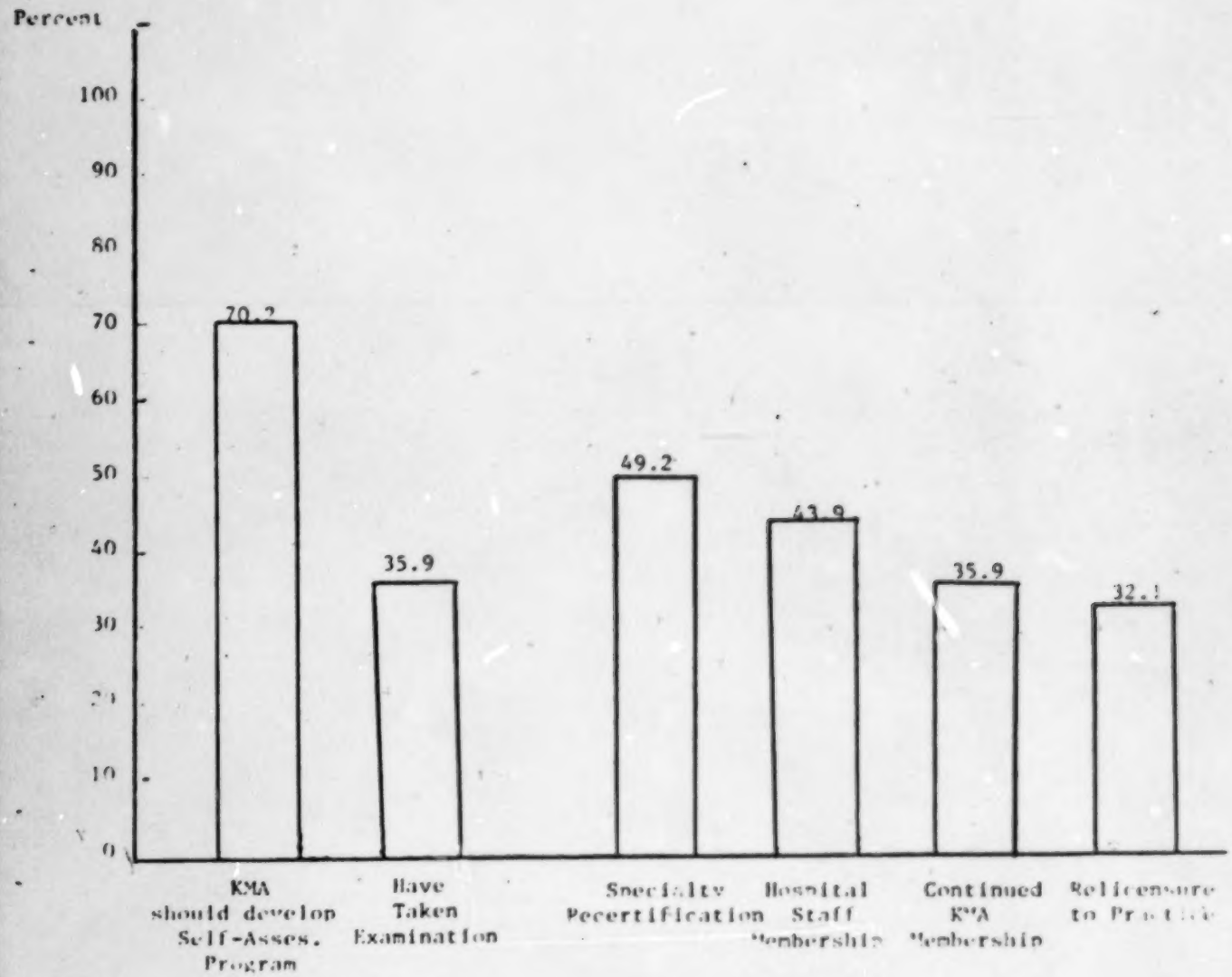
Distribution of Physicians by their Rating of Areas in their Continuing Medical Education that need attention

Area	First	Second	Third	Total
1. Adding new ideas	190	38	11	239
2. Expanding knowledge in a narrow field	27	104	67	198
3. Refreshing aspects seen infrequently	25	76	92	193
4. New medical care delivery concepts	2	22	51	75
5. No Answer	18	22	39	79

Question 9

CHART 3

Distribution of Physicians by Experience with and attitude about Self-Assessment Examination and by Opinion on Mandatory Verified Continuing Education



SELF ASSESSMENT EXAMINATION PROGRAM — MANDATORY VERIFIED CONTINUING EDUCATION

Question 11, 12, 13

8. A matter of increasing public awareness and comment, and government interest, in relation to pay for physician services, and considerable professional society activity has been the matter of C.E. as one essential qualification for continuing membership in hospital staffs and medical societies, specialty recertification and possibly relicensure at stated intervals. New Mexico, now requires satisfactory evidence of a defined C.E. to qualify for license renewal every two or three years. Two or three other states have considered this step. Several states including Arizona, Pennsylvania, Oklahoma, Oregon and others require documentation of C.E. for continued state society membership. In California, a comprehensive medical society inspected and supervised, system of hospital staff C.E. effort, and physician participation, has been established as mandatory to appropriate hospital approval and staff membership.

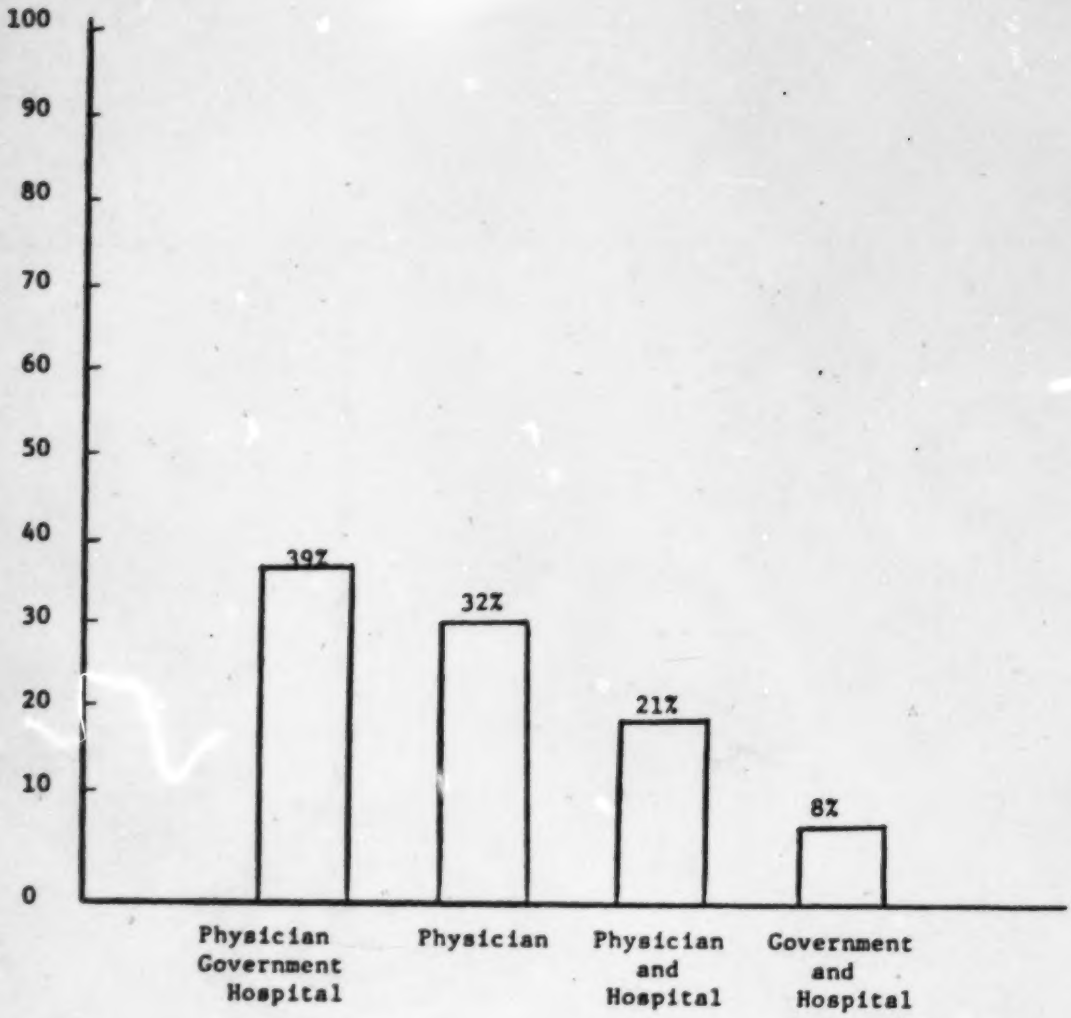
It would appear from this study that Kentucky physicians are not only aware of many of these developments, but have formulated a considerable degree of affirmative support of that trend. This is noted in Chart 3 in which a surprising proportion of physicians expressed an opinion in favor of "verified continuing education essential to": hospital staff and KMA membership, specialty recertification and even a third opted for verification as preliminary to relicensure. Support for mandatory C.E. at these four possible levels receives stronger support by youngest and oldest physicians, relatively strongly by those in general or family practice, and considerably by internists and psychiatrists; also by those who are more rurally located, and those who have taken self-assessment tests. Firm conclusion in any detail on this important contemporary issue would require further study in depth, but, the trend of interest seems definite.

9. Because of the implications of C.E. as an activity which has a bearing on the public and private reimbursement of physicians for service, and its relationship to professional recognition (previous page), there has been of late a debate as to who should be responsible for the costs of that continuing education. Are physicians, wishing to remain free of imposed solutions, and operating self-supporting professional activities, the ones to principally support the C.E. endeavor as a service to their own capabilities and earning power? To what extent should the public and its governmental agencies become involved as support for the practice quality reassurances which they increasingly seek?

The general result of our study (Chart 4) indicates a substantial support (1/3) for primary physician financial responsibility, or at the least shared responsibility, for the costs of C.E.

CHART 4

Distribution of Physicians by Preferred source
for financing continuing education



Conclusions:

In general we draw the following partial and in some areas tentative conclusions from the early stages of analysis of this data based on the sample described which seems to have reasonable capacity for generalization to KMA members as a group but not as individuals.

1. The study incorporates a profile of Kentucky physicians which is generally applicable to urban and rural differentials, and in major specialty but not sub-specialty categories.
2. The sample study group (262 physicians) shares very similar demographic characteristics with non respondents to the study and to a larger number of respondents by mail who were not interviewed as was the sample.
3. KMA members show considerable interest and participation in a variety of forms of C.E. endeavors. Of these they have given high rank to self-instruction by reading, audio-tapes, informal consultations, etc. and a substantial support to more formalized course work.
4. There exists a strong preference for and use of medical center based programs despite a paradoxical recognition that this temporary removal from their practices is impeded by a number of obstacles.

5. Seventy-eight percent (78%) of physicians were not "able to participate in as many C.E. activities" as desired despite the considerable effort and interest displayed.
6. C.E. interest is strong in areas related to staying clinically competent (eg. new ideas, improved special skills, refreshing old competencies); much less, but not absent, in regard to organizational concerns related to the manner in which medicine is to be delivered.
7. There is a considerable interest in self-assessment examinations. One-third have taken them. Almost three-fourths would like to see KMA involved in developing "an anonymous self-assessment program".
8. Kentucky physicians would generally prefer to either support fully, or in substantial partnership with hospitals or government (the public), the financial costs of C.E.

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CONTINUING MEDICAL EDUCATION SURVEY

Fall, 1971

Sponsored by:

Kentucky Medical Association
University of Kentucky Office of Continuing Education

Ohio Valley Regional Medical Program
University of Louisville Office of Continuing Education

1. **Please rate the following methods of continuing education as to their value in assisting you in obtaining useful information and putting it into practice.**

		Very Valuable	*Valuable*	*Not Valuable*	*Never Used*
a.	Medical reading (books, journals, library materials)				
b.	Local medical society meetings				
c.	Hospital staff meetings				
d.	Informal conversations with peers				
e.	Consultations				
f.	State and national medical society meetings				
g.	Audio tape records				
h.	Formal continuing education courses (tuition charged)				
i.	Correspondence courses				
j.	Medical TV programs				
k.	Medical school faculty visiting in your community				
l.	Other (Specify)				
m.					

2. **Please indicate below by identifying letter (from list above) in rank order the 3 types of continuing education most used by you; also, please indicate the amount of time you spend on each method each month or year.**

Method	*Time spent each month/year (Circle one)*
1._____	1._____ mo./yr.
2._____	2._____ mo./yr.
3._____	3._____ mo./yr.

3. **Please indicate below the number of formal continuing education 'courses' (tuition charged) in which you have participated from July 1, 1970 to June 30, 1971.**

_____

4. **Please rate the following techniques of presentation which you have found to be most effective for securing usable information in your continuing education experiences.**

		Most Effective	*Effective*	*Least Effective*
a.	Demonstration (ward rounds & clinics, surgical observation where you are a 'student')			
b.	Group discussion (seminar & study groups)			
c.	Panels and symposia			
d.	Supervised clinical practice (where you are a 'student')			
e.	Laboratory experience			
f.	Lecture			
g.	Film (including movies, slides)			
h.	TV (including closed circuit)			
i.	Audio tapes			
j.	Other (Specify)			
k.				

5. **Indicate by identifying letter (from list above), in rank order, the techniques which are preferred by you.**

1._____ 2._____ 3._____

6. Please circle your answers to the following questions:

a. What location do you prefer for continuing education experiences of any type?

1. County of practice/residence

2. My regional area (multi-county)

3. A major medical center (such as medical school or metropolitan hospitals, etc.)

b. What day of week and time of day is most convenient to you for continuing education activities?

Mon. Tues. Wed. Thurs. Fri. Sat. Morning 9-12

Afternoon 1-5

Evening 7-10

c. Do you prefer regularly scheduled continuing education activities? Yes No

d. How often should such activities be scheduled?

Quarterly -- Monthly -- Bi-monthly -- Weekly -- Sporadic

7. Are you able to participate in as many continuing education activities as you desire? Yes No

8. If your answer to question 7 is NO, please indicate the principal obstacles to your participation.

_____ a. No one to take care of practice
_____ b. Previous unsatisfactory experiences with continuing education activities
_____ c. Lack of continuing education opportunities in area
_____ d. Subject matter which doesn't fit my needs
_____ e. Excessive cost of courses
_____ f. Continuing education opportunities scheduled at inconvenient times
_____ g. Other (Specify)_____
_____ h. _____

9. From the following list please rank in order of importance (1,2, & 3) the areas which you feel should receive the most attention in your continuing medical education.

_____ a. Refreshing those aspects of medicine seen infrequently in practice.
_____ b. Adding new ideas related to methods & techniques of diagnosis and therapy concerning problems most frequently seen in practice.
_____ c. Expanding knowledge in a narrow field which constitutes a large part of your practice.
_____ d. Gaining knowledge concerning new health delivery concepts, e.g., health maintenance organization.
_____ e. (Other)_____

10. Please indicate below the way(s) by which you believe continuing medical education should be financed. (Check spaces below)

_____ a. Physician
_____ b. Government
_____ c. Hospital
_____ d. Government and/or hospital with physician participation
_____ e. Government and/or hospital without physician participation

(Circle)

11. Have you ever taken a 'self-assessment' examination? Yes No

12. Should verified continuing education be essential to:

a. Continued KMA membership? Yes No

b. Hospital staff membership? Yes No

c. Relicensure to practice? Yes No

d. Specialty recertification? Yes No

13. Would you be in favor of KMA's Medical Education Committee developing an anonymous self-assessment program in the interest of defining the educational needs of yourself and your colleagues? Yes No

COMMENTS:

NOTE: Please fold this page over page 1 so that the postage-free return address label is shown. Finally, crease form and tape or staple ends together for mailing.

Thank you very much for your cooperation.